AHCCCS is Arizona's Medical Assistance Program (Medicaid)

AHCCCS

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Report of Continuing Disability

Name of Customer	Social Security Number

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and Social Security number in the space provided and answer all questions. **COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.**

PRIVACY ACT/PAPERWORK ACT NOTICE: The information requested on this form is authorized by the Social Security Act Sections 205(a) and 1631(e)(A)and (B), and Title 20 CFR 404. 1589 and Title 20 CFR 416.989. The information provided will be used to further document your application and permit a determination about your continuing disability. Information requested on this form is voluntary. However, if you do not provide the required information, a decision based on the evidence in your file can result in a determination that your period of disability is ceased. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with Federal laws requiring the exchange of information between the Social Security Administration and another agency.

Please use this form to describe your disabling condition since the date disability began.	Date

Note: All information (except Part II) must reflect the customer's (or his/her representative's) statements regarding the disabling condition since the last interview, i.e., the initial disability application or continuing disability investigation. This report will be one of the criteria used in verifying continuing eligibility for AHCCCS Health Insurance. If, after completion of the investigation, it is determined that there is no longer a disabling condition AHCCCS Health Insurance will be terminated.

PART I – INFORMATION ABOUT YOUR CONDITION

1.a. What is the disabling condition(s) for which you are receiving AHCCCS Health Insurance?

b. Has there been any change (for better or worse) in your disabling condition since you began to receive AHCCCS Health Insurance? ❑ YES ❑ NO (If YES, describe any changes below)

c. Do you have any new injuries or illnesses? ❑ YES ❑ NO (If YES, describe any below)

2.a. Do you feel you are able to return to work?

❑ YES (If YES, explain and described any limitations in Part VI)

❑ NO (If NO, explain how your injuries or illness prevent you from working in Part VI)

b. Has your doctor told you that you are able to return to work?

❑ YES (If YES, answer items c, d and e) ❑ NO ❑ Did not say

c. List the name and address of the doctor(s) who told you to return to work:			
Name			
Address			
d. What date did your doctor tell you that you could return to work?	Month	Day	Year
e. Did the doctor restrict you to limited or part-time work? ❑ YES (If YES, explain in Part VI) ❑ NO			

PART II – INFORMATION ABOUT YOUR MEDICAL RECORDS

Note: When completing Part II, provide a summary of all medical examinations and treatments which you have received in the last 12 months.

3. List the name, address, and telephone number of the doctor who has your latest medical records below:	❑ Check here if you have not seen a doctor

Name	Address	
Telephone Number (including area code)		
How often do you see this doctor?	Date you first saw this doctor (mo./day/yr.)	Date you last saw this doctor (mo/day/yr)
Reasons for visits (show illness or injury for which you had an examination or treatment)		
Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE").		

Name	Address	
Telephone Number (including area code)		
How often do you see this doctor?	Date you first saw this doctor (mo/day/yr)	Date you last saw this doctor (mo/day/yr)
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Name	Address
Telephone Number (including area code)	

How often do you see this doctor?	Date you first saw this doctor (mo/day/yr)	Date you last saw this doctor (mo/day/yr)

Reasons for visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE").

4. Have you been hospitalized or treated at a clinic for your disabling condition?
❑ YES ❑ NO (If YES, fill in the dates below)

Name of Hospital or Clinic	Address
Patient or Clinic Number	

Were you an inpatient (i.e. stayed at least overnight)? ❑ YES ❑ NO (If YES, fill in the dates below)		Were you an outpatient? ❑ YES ❑ NO (If YES, fill in the dates below)
Date(s) of Admission(s)	Date(s) of Discharge(s)	Date(s) of Visit(s)

Reason for Hospitalization or Clinic Visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE").

Name of Hospital or Clinic	Address
Patient or Clinic Number	

Were you an inpatient (i.e. stayed at least overnight)? ❑ YES ❑ NO (If YES, fill in the dates below)		Were you an outpatient? ❑ YES ❑ NO (If YES, fill in the dates below)
Date(s) of Admission(s)	Date(s) of Discharge(s)	Date(s) of Visit(s)

Reason for Hospitalization or Clinic Visits (show illness or injury for which you had an examination or treatment)

Type of treatment or medicines received (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, show "NONE").

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.

5. Have you been seen by other agencies for your injury or illness? (VA, worker's compensation, welfare, etc.).
❑ YES ❑ NO (If YES, fill in the information below)

Name of Agency	Agency Address
Your Claim Number	
Dates of Visits (mo./day, year)	Types of treatments or examination received

If more space is needed, list the other agencies, their address, your claim numbers, dates, and treatment received in Part VI.

6. Have you had any of the following tests?

		If YES, show	
TEST	**YES/NO**	**Where Done**	**When Done**
EKG-Resting	❑ YES ❑ NO		
EKG-Treadmill	❑ YES ❑ NO		
Chest X-ray	❑ YES ❑ NO		
Other X-ray (specify)	❑ YES ❑ NO		
Breathing Tests	❑ YES ❑ NO		
Blood Tests	❑ YES ❑ NO		
Other (specify)	❑ YES ❑ NO		
Other (specify)	❑ YES ❑ NO		
Other (specify)	❑ YES ❑ NO		

PART III – INFORMATION ABOUT YOUR ACTIVITIES

7. Has any doctor told you to cut back or limit your activities in any way since the date shown on Page 1?
❑ YES (If YES, give the name of the doctor below and tell what he/she told you about cutting back or limiting your activities).
❑ NO

Name of Doctor

Explanation of what doctor told you

8. In the areas below, describe your daily activities and state what and how much you do of each, how often you do it, and any assistance you require.

PERSONAL MOBILITY (walking, moving about, exercising your legs, etc.):

PERSONAL NEEDS AND GROOMING (dressing, bathing, etc.):

HOUSEHOLD MAINTENANCE (cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

RECREATIONAL ACTIVITIES AND HOBBIES (hunting, fishing, bowling, hiking, musical instruments, TV, reading, etc.):

SOCIAL CONTACTS (visits with friends, relatives, neighbors):

OTHER (drive car, motorcycle, ride bus, etc.):

9. Have you attended (trade, vocational or academic) school or had any other type of vocational training since you began receiving disability benefits? ❑ YES ❑ NO (If YES, explain below)

10. Are you attending school?
❑ YES ❑ NO (If YES, show the following)

Name of School	Address of School
Current Grade	

PART IV – INFORMATION ABOUT THE WORK YOU DID

When completing Part IV provide information since date you became disabled.

11. Since you became disabled have you done any work?
❑ YES ❑ NO (If YES, show the following for each work attempt, no matter how short it was)

Job Title (be sure to begin with your usual job)	Type of Business	Dates Worked (Month/Year)		Days Per Week	Rate of Pay (per hour, day, week, month or year)
		FROM	TO		

12. Describe your basic duties (explain what you did and how you did it) below. Also, explain why you stopped working for each work attempt listed in item 11.

PART V – INFORMATION ABOUT REHABILITATION SERVICES

13. Vocational Rehabilitation

a. Are you receiving help, such as services, training or counseling from the state vocational rehabilitation agency?
❑ YES ❑ NO (If YES, complete the following)

b. What kind of help have you been receiving?

c. Do you expect to receive any type of training?
❑ YES ❑ NO (If YES, when?)

When

d. What is the name, address, and phone number of your VR counselor?

Name	Address
Telephone Number (including area code)	

PART VI – REMARKS/CUSTOMER INFORMATION

Use this section for additional space to answer any previous questions. Also, use this space to give any additional information that you think will be helpful in making a review of the continuing entitlement to AHCCCS Health Insurance. Additional space is located on page 8. If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.

Does the customer speak English? ❑ YES ❑ NO If NO, what language does the customer speak?

Does the customer need assistance in processing his/her claim? ❑ YES ❑ NO If YES, enter the name, address, phone number and relationship of interested party willing to assist the customer. Also, show why customer requires assistance (foreign speaking, unable to ambulate, etc.)

Name	Relationship
Address	Phone Number (including area code)

Reason the customer requires assistance:

Telephone Number where customer can be reached (including area code)	Best time to reach customer

PART VII – AUTHORIZATION AND NOTIFICATION STATEMENTS

I declare under penalty of perjury under the laws of the State of Arizona that the information on this form is true and correct to the best of my knowledge. I understand that this report will be used to determine whether to continue or to stop my AHCCCS Health Insurance. I also understand that if I am receiving Social Security disability benefits and Supplemental Security Income payments, this questionaire is applicable to all claims.

- Copies of medical records may be provided to a physician or medical institution prior to my appearance for an independent medical examination if an examination is necessary.
- Results of any such independent examination may be provided to my personal physician.
- Medical information may be furnished to any contractor for transcription, typing, record copying, or other related clerical or administrative service performed for the State Disability Determination Service.
- The State Vocational Rehabilitation Agency may review any medical evidence for determining my eligibility for rehabilitative services.
- I agree to notify the AHCCCS Administration if my condition improves or I go to work.
- I know that anyone who makes a false statement or representation of a material fact in an application or for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law. I affirm that the above statements are true.

Name (Signature of customer or person filing on the customer's behalf)	Date (mo/day/yr)

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. Signature of Witness	2. Signature of Witness
Address (number and street, city, state, and zip code)	Address (number and street, city, state, and zip code)

PART VIII – FOR AHCCCS USE ONLY – DO NOT WRITE BELOW THIS LINE

DE-123 Taken by: ❑ Personal Interview ❑ Telephone ❑ Mail	Form Supplemented ❑ YES ❑ NO If YES, by: ❑ Personal Interview ❑ Telephone ❑ Mail

Signature of Eligibility Specialist	Date (mo/day/yr)

ADDITIONAL COMMENTS/REMARKS/INFORMATION